

Michigan Department of Community Health
Board of Counseling
P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918

COUNSELOR LICENSURE INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Counseling. Questions regarding your application can be directed to the Michigan Board of Counseling at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee will be returned.

LIMITED LICENSE

1. Complete the Counselor License Application form and submit it, along with the appropriate fee, to the Board of Counseling office. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.
2. **EDUCATIONAL REQUIREMENTS:** To be eligible, an applicant must have obtained a minimum of a master's degree in a counseling or student personnel work program of not less than 48 semester hours or 72 quarter hours which included studies in all of the following: career development; consulting; counseling techniques; counseling theories; counseling philosophy; group techniques; professional ethics; research methodology; testing procedures; practicum; AND an internship that consists of not less than 600 hours of supervised clinical experience in the practice of counseling.
 - a. Arrange for an **official transcript** of your graduate education to be forwarded directly to this office from the registrar of your educational institution. **STUDENT COPY TRANSCRIPTS WILL NOT BE ACCEPTED.**
 - b. Complete Section I of the **Certification of Counseling Education** form and forward it to the Director of your Counselor Education Program for certification of the education program you completed. Your Certification of Counseling Education form must be received in this office directly from your educational institution.
3. Professional Disclosure Statement - **See last page of instructions.**
4. Completed license verification forms must be received from every state in which you hold or have ever held a permanent Counseling license.

ORIGINAL LICENSES ARE VALID FOR A YEAR OR LESS, SUBSEQUENT RENEWALS ARE FOR A ONE-YEAR PERIOD.

FULL PROFESSIONAL COUNSELOR LICENSE BY EXAMINATION

(Those with a degree and experience before October 1, 1993 see #8 on page 2 of these instructions.)

1. Complete the Counselor License Application form and submit it, along with the appropriate fee, to the Board of Counseling. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.
2. **EDUCATIONAL REQUIREMENTS:** Meet the educational requirements as indicated above for a Limited License.

3. **EXPERIENCE:** Counseling experience under the supervision of a licensed professional counselor is required to qualify for a full professional counselor license. Individuals with a Master's degree must accrue 3,000 hours of post-degree counseling experience in not less than a two-year period with at least 100 hours accrued under the immediate physical presence of the supervisor. **OR**, individuals who have completed 30 semester hours or 45 quarter hours of graduate study in counseling beyond a Master's degree must accrue 1,500 hours of post degree counseling experience in not less than a one year period with at least 50 hours accrued in the immediate physical presence of the supervisor.
4. Arrange for a completed **Counseling Work Experience** form to be submitted directly to the board office from your supervisor.
5. **EXAMINATION:** An applicant for Professional Counselor Licensure shall have passed one of the following examinations: The National Board for Certified Counselors Examination (see enclosed NBCC form) **or** the Commission on Rehabilitation Counselor Certification (CRCC) Examination. (CRCC, 1815 Rohlwing Road, Suite E, Rolling Meadows, IL 60008; telephone (847) 394-2104.) Arrange for the examination agency to forward an official copy of your scores directly to this office.
6. Professional Disclosure Statement - **See last page of instructions.**
7. Completed license verification forms must be received from every state in which you hold or have ever held a counseling license.
8. **NOTE:** An individual who received a master's or doctoral degree in counseling or student personnel work by October 1, 1991 and had two years of experience by October 1, 1993 may be issued a full professional counselor license by doing the following:
 - a. Complete the Counselor License Application form and submit it, along with the appropriate fee, to the Board of Counseling office. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.
 - b. Arrange for an **official transcript** of your counseling or student personnel work education to be forwarded directly to this office from the registrar of your educational institution. **STUDENT COPY TRANSCRIPTS WILL NOT BE ACCEPTED.**
 - c. Professional Disclosure Statement - **See last page of instructions.**
 - d. Completed license verification forms must be received from every state in which you hold or have ever held a permanent Counseling license.

FULL PROFESSIONAL COUNSELOR LICENSE BY ENDORSEMENT - Requires the applicant to be currently licensed as a professional counselor in another state and meet the following:

1. **If you have held licensure in another state and you have been engaged in the practice of counseling for a minimum of five years before the date of filing for a Michigan license:**
 - a. Complete the Counselor License Application form and submit it, along with the appropriate fee, to the Board of Counseling office. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.
 - b. Professional Disclosure Statement - **See last page of instructions.**
 - c. Completed license verification forms must be sent directly to this office from every state in which you hold or have ever held a Counseling license.
2. **IF YOU HAVE NOT BEEN LICENSED IN ANOTHER STATE FOR A MINIMUM OF FIVE YEARS, YOU MUST APPLY BY EXAMINATION. PLEASE REFER TO THE INSTRUCTIONS ABOVE.**

PROFESSIONAL DISCLOSURE STATEMENT

Section 18113 of the Michigan Public Health Code, 1978 PA 368, as amended, requires that a licensed counselor furnish a Professional Disclosure Statement to all prospective clients before engaging in counseling services. **A copy of your Professional Disclosure Statement must accompany your application for licensure. THE PROFESSIONAL DISCLOSURE STATEMENT YOU DEVELOP AND SUBMIT WITH YOUR APPLICATION MUST CONTAIN ALL OF THE FOLLOWING:**

1. Your name, business address, and telephone number.
2. A description of your practice.
3. A description of your education and experience.
4. Your counseling fee schedule. (The fee you charge your clients. If you do not charge a fee, you must specifically state that you do not charge a fee.)
5. The name, address and telephone number of this agency as follows: Michigan Department of Community Health, Complaint and Allegation Division, P.O. Box 30670, Lansing, MI 48909, (517) 373-9196*

*NOTE: This information is to be provided solely for the use of your clients in the event that they want to file a complaint regarding your services. This address is **NOT** to be used for any other purpose. All other correspondence to the Board should be addressed to the Michigan Board of Counseling, P.O. Box 30670, Lansing, MI 48909.

In order for your license to be issued, a Professional Disclosure Statement is required from every applicant, even if you are not currently practicing. **Your license cannot be issued without your disclosure statement(s) on file.** If you use different disclosure statements for different practice locations, you must submit a copy of your disclosure statement for each location. A new disclosure statement must be submitted to this office within 30 days after a change in any of the required information listed above.

ORIGINAL LICENSES ARE VALID FOR A YEAR OR LESS, SUBSEQUENT RENEWALS ARE FOR A THREE-YEAR PERIOD.

Michigan Department of Community Health

Michigan Board of Counseling

P.O. Box 30670

Lansing, MI 48909

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MICHIGAN LICENSURE EXAMINATION REGISTRATION National Counselor Examination for Licensure and Certification (NCE)

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, certification will not be issued.

Type or Print Only

Last Name		First Name		Middle Name	
Social Security Number — — — — —		Home Phone ()		Business Phone ()	
Street Address					
City		State		Zip Code	
Check One	Exam Date	Registration Deadline	Exam Location	Site ID	
<input type="checkbox"/>	January 17, 2003	December 1, 2003	Rochester	2204	
<input type="checkbox"/>	April 24, 2004	March 1, 2004	Lansing	2201	
<input type="checkbox"/>	July 24, 2004	June 1, 2004	Lansing	2203	
<input type="checkbox"/>	October 23, 2004	September 1, 2004	Rochester	2212	
ABOUT REGISTRATION a. The cost to register is \$120. This examination fee is non-refundable/non-transferable. b. Registration is required. Deadlines are strictly enforced. c. All exam registration materials must be received by the registration deadline (postmarks do NOT count). d. You will receive your admission ticket approximately two weeks prior to the exam date. e. Your admission ticket will include information regarding the date and location of the exam.			PLEASE INCLUDE WITH YOUR MATERIALS a. Your completed registration form with signature. b. Your \$120 examination fee (please make check or money order payable to NBCC). WHERE TO SEND YOUR REGISTRATION MATERIALS NBCC PO BOX 651051 Charlotte, NC 28265-1051		
QUESTIONS ABOUT THE EXAMINATION? Tel: (336) 547-0607; fax: (336) 547-0017; E-mail: nbcc@nbcc.org					

I understand that I am taking the NCE for the purpose of fulfilling requirements for counseling certification in Michigan. I authorize the NBCC to provide the Michigan Board of Counseling with examination results. Use of the NCE scores for licensure in other states may not occur until licensure is granted in Michigan.

If I am applying to take the examination solely for Michigan licensure, as opposed to certification, I stipulate that (1) I hold a master's degree in counseling or student personnel work; (2) I intend to apply for licensure as a professional counselor in Michigan within two years; and (3) I will not use the examination results for licensure in another state for at least one year following receipt of a passing score.

Signature: _____ Date: _____

Subscribed and sworn to before me this _____ day of _____, _____
(Month) (Year)

Notary Public Signature

My Commission Expires _____

County/State _____

CHARGE ORDER FORM - DO NOT DETACH

Credit card type: VISA ☐ Mastercard ☐ American Express ☐

Account Number: _____ Exp. Date: _____

Name on card: _____ Amount Charged: \$ _____

Signature: _____ Date: _____

Board of Counseling

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CERTIFICATION OF COUNSELING EDUCATION

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, certification will not be issued.

INSTRUCTIONS: Type or print your name exactly as it appears on your application. Complete Section I and, if necessary, Section II. Forward this form to the director of your counseling education program for completion of **Section II. This certification must be submitted directly to the Michigan Board of Counseling by your educational institution.**

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	
Name of Educational Institution	Date Degree Granted	
Level of Degree Granted	Discipline/Program Title	
Date of Admission		
Was the program you completed accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Was the program you completed accredited by the Council on Rehabilitation Education (CORE)?		<input type="checkbox"/> Yes <input type="checkbox"/> No

If the answer is Yes to either of the above questions, it is not necessary to complete Section II. Please sign and forward to your educational institution for completion of Section III on the reverse side of this form.

SECTION II - PROGRAM INFORMATION

Was the institution you attended accredited by the regional accrediting body of the Council for Higher Education Accreditation (CHEA)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
My counseling education program consisted of areas of study in the courses indicated below as defined in Rule 338.1751 of the Board's Administrative Rules. List course titles and course numbers for each area below.		
CAREER DEVELOPMENT:	CONSULTING:	
COUNSELING PHILOSOPHY:	GROUP TECHNIQUES:	
COUNSELING TECHNIQUES:	RESEARCH METHODOLOGY:	
TESTING PROCEDURES:	PROFESSIONAL ETHICS:	
COUNSELING THEORIES:		

In addition to a practicum, did your counseling education program include an internship of at least 600 hours of supervised clinical experience?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was the program you completed at least 48 semester hours or 72 quarter hours?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Signature of Applicant	Date of Signature		

Applicant: Upon completion of Section I and II, send this form to your educational institution for completion of Section III.

EDUCATIONAL INSTITUTION INSTRUCTIONS:

Please complete Section II below and forward the completed form to the Michigan Board of Counseling office at the address on Page 1 of this form. Attach additional sheets if needed to clarify the information provided by on the certification.

SECTION III - CERTIFICATION OF COUNSELING PROGRAM

Name of Educational Institution	
Street Address of Institution	
City, State and ZIP Code	
<p>I certify that _____ attended the educational institution named above from _____, to _____, Month/Day/Year Month/Day/Year and was granted a _____ degree in _____, (level) (Discipline/Program Title) and that the information provided on the Page 1 of this form regarding the program of counseling education completed by this applicant is correct.</p>	
_____ Signature of Program Representative	_____ Date of Signature
_____ Print or Type Name of Program Representative	
_____ Telephone Number of Program Representative	
(S E A L)	

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COUNSELING WORK EXPERIENCE FORM

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, certification will not be issued.

INSTRUCTIONS: Type or print your name exactly as it appears on your application. Send this form directly to your professional counseling supervisor for completion of Section II. **THIS FORM MUST BE SUBMITTED DIRECTLY TO THE MICHIGAN BOARD OF COUNSELING BY YOUR SUPERVISOR.**

SECTION 1 - APPLICANT INFORMATION: Complete this section and forward to your supervisor.

Applicant's Name	Michigan Permanent License Number (if applicable)
U.S. Social Security Number	Telephone Number

EXPERIENCE - Counseling experience under the supervision of a licensed professional counselor is required to qualify for a full professional counselor license. Individuals with a master's degree must accrue 3,000 hours of post-degree counseling experience over a period of at least two years, with a minimum of 100 hours accrued under the immediate physical presence of the supervisor. Individuals who have completed 30 semester hours or 45 quarter hours of graduate study in counseling beyond a master's degree must accrue 1,500 hours of post-degree counseling experience in a period of at least one year, with a minimum of 50 hours accrued in the immediate physical presence of the supervisor.

SECTION II - INSTRUCTIONS TO SUPERVISOR: Complete the remainder of this form and return it to the Board of Counseling at the address given above.

Supervisor's Name	Michigan Permanent I.D. Number (if applicable)
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Please answer the following questions about your credentials at the time you supervised the applicant.

For work experience in Michigan:

Were you a licensed professional counselor in Michigan at the time you supervised the applicant?

☐ Yes ☐ No

For work experience in other state:

Were you licensed or certified as a professional counselor in the state where you were providing supervision?

☐ Yes ☐ No

State _____ Type of License or Certificate _____

Please answer the following questions about your supervision of the above named applicant's professional experience in the practice of counseling.

What was your title at the time of supervision?

What was the applicant's title at the time of supervision?

Describe Applicant's Duties _____

Name

I hereby certify that _____ practiced counseling under my supervision at
Applicant's Name

located at

Name of Agency

Address

from _____ to _____ for a total of _____ hours.
Month/Day/Year Month/Day/Year

At least ☐ 50 or ☐ 100 hours were accrued in my immediate physical presence.

Supervisor's Signature

Date

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Board of Counseling
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DCH/LCN-010 (03/04)

Page 1 of 3

APPLICATION FOR LICENSURE AS A COUNSELOR

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

- ☐ Professional Counselor License by Exam - Fee: \$115.00 71-6401-01
- ☐ Professional Counselor License by Endorsement - Fee: \$115.00 71-6401-09
- ☐ Limited Counselor License - Fee: \$80.00 71-6401-03
- ☐ Professional Counselor License, Grandfathering - Fee: \$115.00 71-6401-05

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application.
DO NOT SEND CASH. Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

Board Use Only

License Number

Date of Licensure

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Michigan Permanent I.D. Number and Expiration Date:
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	
Have you ever held a health professional license in Michigan?		
<input type="checkbox"/> No <input type="checkbox"/> Yes		

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you been treated for substance abuse in the past 2 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

www.michigan.gov/healthlicense

Name

7. Have you ever had a federal or state health professional license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you? ☐ Yes ☐ No
8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? ☐ Yes ☐ No
9. Do you hold or have you ever held a full counselor license in any state? List each state, the license number, the date issued, and how the license was obtained. **DO NOT LIST TEMPORARY LICENSES. You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.)** ☐ Yes ☐ No

State	License/Registration Number	Date of Issue	How obtained (Endorsement or Examination)

Provide a complete chronological record of your educational preparation.
Attach additional sheets if necessary.

Name and Address of Institution	Dates of Attendance From To		Degree

Name

Provide a description of your professional counseling experience.

Attach additional sheets if necessary.

Name and Address of Employer	Dates of Practice From	To	Duties

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date
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Michigan Department of Community Health

Bureau of Health Professions

P.O. Box 30670

Lansing, MI 48909

VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.		
<input type="checkbox"/> Chiropractic <input type="checkbox"/> Counseling <input type="checkbox"/> Dentistry <input type="checkbox"/> Marriage & Family Therapy <input type="checkbox"/> Medicine	<input type="checkbox"/> Nursing <input type="checkbox"/> Nursing Home Adm. <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Optometry <input type="checkbox"/> Osteopathy	<input type="checkbox"/> Pharmacy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Physician's Assistants <input type="checkbox"/> Podiatry <input type="checkbox"/> Psychology
	<input type="checkbox"/> Sanitarians <input type="checkbox"/> Social Work <input type="checkbox"/> Veterinary	
First Name	Middle Name	Last Name
Previous Names Used	Date of Birth	U. S. Social Security Number
State Board	License Number	Date of Issue

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State. Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Basis for Issuance of License:		Type of License:
<input type="checkbox"/> Examination - Please indicate type of exam (National, Regional, State, etc.)	<input type="checkbox"/> Endorsement - Please indicate name of state	
License Status	Original Issue Date	Expiration Date
<input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive		
Has the applicant incurred any formal or informal actions in your State?		
<input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, Please attach certified copies of any actions.		
Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

Signature

Date

Type or Print Name

(S E A L)

Title

Full Name of Licensing Board